

March 18, 2019

Testimony for H.B. 5898, An Act Concerning Aid in Dying for Terminally Ill Patients

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Senator Abrams, Representative Steinberg and members of the Public Health Committee,

How ironic that we are moving away from capital punishment for people convicted of heinous crimes considering this cruel and unusual, but are increasingly endorsing the active taking of life in the medical setting, calling this choice or death with dignity.

As a physician, I strongly endorse maximizing patient choice in all situations including facilitating access to accepted medical therapy, and expanding access to compassionate release procedures and medications for those who wish to exercise every treatment option. For others, palliative care in which patient comfort becomes the goal of therapy rather than trying to induce cure or remission is an appropriate choice, and we have a wonderful mechanism to do this in a supportive and empathetic environment with hospice care. But I cannot support physician directed taking of human life, either by prescription of lethal drugs (physician assisted suicide) or direct termination of life (euthanasia).

It is not a question of whether there will be cases where this power is misused, it is a question of how long before it occurs and how severe the abuses are. Already we see this in Holland where euthanasia/assisted suicide deaths have increased to 4.5% of all deaths and where requests are being approved for even non-lethal diseases, such as depression which is treatable. However, since it is difficult at times to be able to differentiate depressive mood symptoms from those of the systemic disease, some patients here may be given life ending medication who could have been treated.

For me, the defining moment cementing my opposition to physician directed end of life was the egregious experience with DNR (Do not Resuscitate) decisions imposed on two of my patients and their families. However, please note that these types of experiences to varying degrees are not uncommon for patients and their families. These cases below refer to a decision not to attempt to prolong a life that might end without treatment. But how much more difficult and contentious would it be to decide to actively terminate life as this bill allows?

The first was a woman in her 80s who suffered from heart valve disease and dementia. She had a loving and devoted daughter who chose to take excellent care of her mother and only brought her for medical care when absolutely needed. Even though the patient had difficulty communicating with the staff which was frustrating to them, she continually told her daughter, "Don't let me die and Don't leave me." Each time she needed hospital care, the staff recommended that a DNR order to be put in the record. Overtime, the staff stridency rose to the level of what could be described as brow beating of the daughter, accusing her of being selfish and not having the best interests of her mother at heart. The patient lived another year after this and died a natural death.

In another case, the patient was 95 and had advanced pulmonary disease but was entirely lucid mentally. She had recurrent pulmonary infections cared for by her physician assistant daughter. One occasion required a hospital admission. The admitting staff discussed DNR with her privately and shared

that she was “ruining her daughter’s life” and “requiring immense resources that could be used for more treatable younger patients.” This particular patient who was entirely articulate responded that she would not allow it to be dictated to her when it was time to die.

The vast majority of health care personnel are kind, compassionate and empathetic, but with all of the pressures to deliver cost effective and speedy care, might we not have to worry that advice from our health care team might be, at least in part, motivated by factors other than those related to our immediate benefit such as cost? How does it change the doctor-patient relationship if some part of us need to be concerned about it? As I learned in those DNR discussions at least sometimes, the health care team found it hard not to pressure patients to cooperate with their treatment biases and not to impose their value system on others.

I think that we all have to be cognizant of what has happened previously in history when governments joined with the medical community in the endorsement of eugenics, involuntary sterilization, rendering experimental treatment on unwitting patients, the “T4” program in Germany and the “selections” during the Holocaust, and the atrocities by unit 731 in China during WWII. Let’s concentrate instead on the normal role of physicians in promoting cure, remission and when appropriate, palliation up to and including continuous opiate infusions for those with intractable pain.